



9/1/2015

CHRISTINE SOLTAU
CITY OF ROCHESTER - 010993
201 4TH ST SE
ROCHESTER, MN 55904

Dear Group Contact:

Thank you for trusting SelectAccount to administer your medical spending account(s). Your annual renewal date is right around the corner, which means this is the perfect time to review your current plan and make changes, as needed.

Renewing your account is easy. Simply select one of the following options:

- ☒ **Keep your current plan design.** You aren't required to return the renewal packet and your plan will be automatically renewed with the same features and options. If you'd like, you can sign this page and return it to SelectAccount, but this is not necessary when keeping your current plan design. Members must make an FSA election for the new plan year and is due 30 days prior to your renewal date.
- ☐ **Change your plan design.** Indicate the changes in the Plan Changes section near the end of the document. Return the entire Plan Changes section, along with a signed copy of this page to SelectAccount 60 days prior to your renewal date. You may also email your completed form to SelectAccount.Group.Administration@SelectAccount.com; fax it to (651) 662-1180 or 1-866-231-0214 (toll-free); or mail it to SelectAccount at P.O. Box 64193, St. Paul, Minnesota 55164-0193. You will receive a confirmation email from SelectAccount when your renewal has been received.

Please note: members must make an FSA election for the new plan year. You can enter election amounts online or you may use the enrollment form available on the Online Group Service Center for your employees to complete. Enrollment information is due 30 days prior to your renewal date.

If you would like to make changes to your contact information, please complete the Group Contact Change Form which is available at SelectAccount.com

SIGNATURE

I agree that the necessary information concerning employees and/or their dependents participating in, either now or after the effective date of our plan, and employees whose participation is changed or discontinued, shall be furnished to SelectAccount on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES IN THIS PACKET. INFORMATION ON THE RENEWAL FORM AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE. PENDING 2016 BUDGET APPROVAL BY THE ROCHESTER CITY COUNCIL.

Employer's Signature

11/23/2015

Date

Ardell Brede

Mayor

Printed Name

Title

For any questions about your renewal, please work with your Agent, Account Manager, or contact the SelectAccount Group Leader Line at 1-888-460-4013. We appreciate your business and look forward to working with you during the upcoming plan year.

Attested by:

11/23/2015



**010993 - CITY OF ROCHESTER
2016 Spending Account Fee Illustration**

Spending accounts offer significant tax savings for you and your employees. SelectAccount's comprehensive suite of administrative services makes it easy and convenient for you to offer these tax-advantaged accounts to your employees.

Plan Administration - The administration of your plan includes the following:

- Enrollment Materials (enrollment form, product brochure, planning worksheet, sample claim forms and updates)
- Member Welcome Packet (welcome letter and election verification statement)
- Spending Account Call Center dedicated to serving your members (Monday – Friday, 7:00 am to 8:00 pm CT)
- Dedicated Group Leader Phone Line (Monday – Friday, 8:00 am to 5:00 pm CT)
- 24/7 toll-free Interactive Voice Response (IVR) phone system
- Online account management tools for both you and your employees

The following chart illustrates our pricing model:

FSA

Employer Annual Fees

- | | |
|--|----------------|
| • Annual fee | \$400 |
| • Multiple product stacking fee | \$250 |
| • Manual payroll fee – applies if payroll information is not submitted in standard SelectAccount-specific electronic format | \$250 |
| • Nondiscrimination testing - upon request | \$250 per test |

Monthly Participant Fees

- | | |
|---|------------|
| • Standard | \$4.50 ppm |
| ○ Debit cards are auto issued to all <u>new members</u> and | |
| ○ The group must elect ACH for administrative fees and claims | |
| • Non-Standard - if above requirements are not met | \$4.70 ppm |

HRA

Monthly Participant Fees

- | | |
|---|------------|
| • Standard | \$4.50 ppm |
| ○ Auto-enroll members in crossover and | |
| ○ The group must elect ACH for administrative fees and claims | |
| • Non-Standard - if above requirements are not met | \$4.70 ppm |

HSA

Employer Annual Fees

- | | |
|---|----------------|
| • Nondiscrimination testing - upon request | \$250 per test |
|---|----------------|

Monthly Participant Fees

- | | |
|-----------------------|------------|
| • PremiumSaver | \$4.00 ppm |
| • BasicSaver | \$2.50 ppm |
| • ThriftSaver | \$1.00 ppm |
| • SelectSaver | \$3.00 ppm |

A debit card is issued to all members.

Additional Features

- | | |
|---|------------|
| • Debit card | Included |
| • WalletDoc | \$1.50 ppm |
| • Pay-the-provider option - applies to entire population | \$0.50 ppm |
| • EE Pays First HRA option | \$0.50 ppm |

Highest participant fee applies for stacked accounts, all other accounts included
ppm = per participant per month



RENEWAL REQUEST FORM
010993 - CITY OF ROCHESTER

Please make any changes to your plan in the Plan Changes Section. Please refer to the glossary on our website for descriptions of plans and optional features.

- You will receive a confirmation email from SelectAccount once your renewal request has been received.
- If you are adding a new spending account plan, you will need to complete a Plan Design Guide for each new plan.
- If you do not wish to renew your plan(s), please call the Group Leader Line at 1-888-460-4013 to discuss your options.
- **Participant enrollment is due to SelectAccount 30 days prior to your renewal effective date. If enrollment is not received by the renewal effective date then claims will be placed on hold until enrollment is received and updated.**
- Making your first payment to SelectAccount (either through direct check or account transaction) will signify your Company's acceptance of all terms, fee, conditions and obligations. Acceptance will be effective on the renewal date.

YOUR EMPLOYER INFORMATION

Please review the following employer information to ensure that it is correct. If you have changes to your employer information clearly note them within this box. All information in this box is necessary to administer your account in the upcoming plan year.

Employer's Name: **CITY OF ROCHESTER**
Employer's Street Address: **201 4TH ST SE**
City: **ROCHESTER** State: **MN** Zip Code: **55904**

Total # eligible employees: ~~8~~ 850

Primary Contact Person: **CHRISTINE SOLTAU**
Email Address: **csoltau@rochestermn.gov**
Phone Number: **(507) 328-2564** Fax Number: **(507) 328-2565**

(If you would like to make changes to the contact information, update this information using the online group service center or complete the Group Contact Change Form (F9333).)

Agent Name: **<NOT APPLICABLE>**
Agency Name: **<NOT APPLICABLE>**

(If there are changes to the agent and/or agency information, call the Group Leader Line at 1-888-460-4013 for further details.)

Health Plan: **Mayo Clinic Health Solutions, Rochester MN.**



RENEWAL REQUEST FORM
010993 - CITY OF ROCHESTER

CURRENT PLAN OPTIONS

YOUR PREMIUM ONLY PLAN DESIGN

Plan Year Start: 1/1/2016 Plan Year End: 12/31/2016

You currently offer a premium only plan - Yes

YOUR MEDICAL FSA PLAN DESIGN

Plan Year Start: 1/1/2016 Plan Year End: 12/31/2016

Minimum and Maximum Contribution Limits

Plan Year Minimum: \$ 50 Plan Year Maximum: \$ 2550 (IRS Maximum is \$2,550)

The Employer contributes to the account - No

Grace Period

You currently offer a grace period on your Medical FSA - No

Runout Period

You currently offer a runout period on your Medical FSA - Yes

Runout Period: 3 months

Account Rollover

Your current account rollover election is: **No balance rolls over**

YOUR DEPENDENT CARE FSA PLAN DESIGN

Plan Year Start: 1/1/2016 Plan Year End: 12/31/2016

Minimum and Maximum Contribution Limits

Plan Year Minimum: \$ 50 Plan Year Maximum: \$ 5000 (IRS Maximum is \$5,000)

The Employer contributes to the account - No

Grace Period

You currently offer a grace period on your Dependent Care FSA - No

Runout Period

You currently offer a runout period on your Dependent Care FSA - Yes

Runout Period: 3 months

YOUR FSA PAYROLL REPORTING INFORMATION

Your FSA Payroll Reporting Information will be sent via Paper Report

YOUR HSA PLAN DESIGN

HSA Plan Options

Your current HSA plan option is: Thrift Saver

HSA Participation Fees



RENEWAL REQUEST FORM
010993 - CITY OF ROCHESTER

Your HSA participant account fees are currently: **Employer Paid**
Billing frequency: **Monthly**

YOUR PLAN(S)' CURRENT OPTIONAL FEATURES - FSA/HRA

Debit Card

Your current debit card election is: **Offer debit card to participants**

YOUR PLAN(S)' CURRENT OPTIONAL FEATURES - HSA

Effective with your new plan year, all HSA participants will be automatically issued one debit card. There is no fee for the debit card and participants can request additional cards for their dependent(s) online at selectaccount.com



RENEWAL REQUEST FORM
010993 - CITY OF ROCHESTER

PLAN CHANGES

Please use this section to indicate any changes you wish to make to your plan for the upcoming plan year.

Optional Features - FSA/HRA

Debit Card

- ☐ New participants will be offered a debit card. Only new participants are issued a debit card and existing participants elections remain the same.
- ☐ New participants and existing participants not enrolled in crossover will be issued a debit card automatically. Existing participants in crossover will remain in crossover.
- ☐ All participants will be offered a debit card. New participants will be issued a debit card and existing participants will be opted out of crossover and issued a debit card.

Medical FSA

Plan Year Start: _____ Plan Year End: _____

Minimum and Maximum Contribution Limits

Plan Year Minimum _____ Plan Year Maximum _____ (IRS maximum is \$2,550)

Does the Employer contribute to any account(s)? [] Yes [] No

Grace Period [] Yes [] No Grace Period End Date: _____

Runout Period [] Yes [] No Runout Period: _____ months

Account Rollover

- ☐ Roll over balance up to \$500 to subsequent plan year
- ☐ No balance rolls over

Dependent Care FSA

Plan Year Start: _____ Plan Year End: _____

Minimum and Maximum Contribution Limits

Plan Year Minimum _____ Plan Year Maximum _____ (IRS maximum is \$5,000)

Does the Employer contribute to any account(s)? [] Yes [] No

Grace Period [] Yes [] No Grace Period End Date: _____

Runout Period [] Yes [] No Runout Period: _____ months

HSA



RENEWAL REQUEST FORM
010993 - CITY OF ROCHESTER

HSA Plan Option

- ☐ ThriftSaver
- ☐ BasicSaver
- ☐ PremiumSaver
- ☐ SelectSaver

Participant Fees (If your group offers another medical spending account with SelectAccount, the fees must be Employer Paid and billed monthly.)

- ☐ Employer Paid.
Indicate the billing frequency:
 - ☐ Annually
 - ☐ Monthly
- ☐ Employee Paid. Billed annually and taken directly from participant's account balance.



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